CMS–500 (11/10)

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

NOTICE OF MEDICARE PREMIUM PAYMENT DUE

BILLING NOTICE DATE: _____

YOUR CLAIM NUMBER:

<Type Address Here.>

Use Visa/MasterCard/American Express/Discover or make check/money order payable to "CMS Medicare Insurance." Send payment with the bottom portion of this notice in the enclosed envelope to:

Medicare Premium Collection Center
P.O. Box 790355
St. Louis, MO 63179-0355

	Hospital Insurance Part A	+ Medical Insurance Part B	+ IRMAA Part D	= Total Amount
Current amount due for Part A and/or Part B	$	$	$	$
Past due amount for Part A and/or Part B	$	$	$	$
Current amount due for IRMAA Part D	$	$	$	$
Past due amount for IRMAA Part D	$	$	$	$

Part A: TERMINATION DATE:

Part B: TERMINATION DATE:

TOTAL AMOUNT DUE: $

PAYMENT DUE BY:

Last payment received: _____ on _____ .

To ensure timely processing, payments must be received by _____. Any payments received after this date will be included in your next notice.

SEE OTHER SIDE FOR IMPORTANT INFORMATION

Please tear at dotted line and return bottom portion with payment

<Type Address Here.>

☐ If your name or address has changed or is incorrect, check here and complete the back of this notice.

☐ If the person is deceased, check here.

CLAIM NUMBER:

Show claim number on check or money order.

AMOUNT PAID: $ ____ . __

AMOUNT DUE: $_____ DUE BY: _____

VISA/MASTERCARD/AMERICAN EXPRESS/DISCOVER NUMBER:

____ - ____ - ____ - ____

EXP. DATE: __ - __ - __

SIGNATURE:

Make check/money order payable to: CMS MEDICARE INSURANCE

DO NOT SEND CASH OR STAMPS.

SEND PAYMENT TO:

MEDICARE PREMIUM COLLECTION CENTER
P.O. BOX 790355
ST. LOUIS, MO 63179-0355

(over)

IMPORTANT MEDICARE CUSTOMER INFORMATION

- Failing to pay Part A or Part B premiums will result in termination of your Medicare insurance. Even if your Medicare insurance ends, you must pay the total premium amount already due. You may reapply only during the General Enrollment Period, which is January, February, and March of each year. If you reapply, your coverage will begin on July 1 of the year you reapply. Please note that your payment amount may be higher because of the interruption of coverage.
- This bill may include an Income Related Monthly Adjustment Amount (IRMAA) for Part B based on your income.
- If you have any questions about this notice, your Medicare Part A or Part B insurance, or the amount you have to pay, please write or visit any Social Security Administration office, or call 1-800-772-1213. TTY users should call 1-800-325-0778.
- This bill may include an IRMAA for Part D. If you have any questions about your IRMAA Part D Bill amount, please call 1- 800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Failure to pay the IRMAA Part D may result in disenrollment from your Prescription Drug Plan.

SPECIAL MESSAGES

MEDICARE EASY PAY

Sign up to have your Medicare premiums automatically deducted from a bank account each month and you won't have to worry about late or lost payments.

If you want to sign up for Automated Clearing House (ACH), automated premium payment deductions from your checking or savings account, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

PAYMENTS BY CHECK

When you provide a check as a payment, you authorize the Medicare Premium Collection Center (MPCC) to use the information from your check to make a one-time electronic funds transfer from your bank account. When the MPCC uses information from your check to make an electronic funds transfer, funds may be withdrawn from your bank account as soon as the same day your payment is received. You won't get your check back from your bank. If the MPCC can't process your payment electronically, it will be processed as a check transaction. Your bank statement will show the transaction as "CMS Medicare" and this is your proof of payment.

IF YOUR NAME OR ADDRESS HAS CHANGED OR IS DIFFERENT FROM THE NAME OR ADDRESS SHOWN ON THE FRONT OF THE FORM, PLEASE PRINT CORRECT INFORMATION BELOW:

Last Name: First Name: MI:

Street Number: Street Name:

P.O. Box: Apartment Number:

City: State: Zip Code: –